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Office of Administrative Law Judges
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Issue Date: 04 August 2005

In the Matter of:

JUNIOR R. LOWE,
Claimant

Case No.: 2003-BLA-6697

v.

KEY MINING INC.,
Employer

and

AMERICAN MINING INSURANCE CO.,
Carrier

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest

Appearances:

Robert Patterson, Esq.
Peter Angelos Law Firm
Knoxville, Tennessee 37919
For the Claimant

Natalee A. Gilmore, Esq.
Jackson & Kelly
Lexington, Kentucky 40588
For the Employer

Before: Alice M. Craft
Administrative Law Judge

DECISION AND ORDER DENYING BENEFITS

This proceeding arises from a claim for benefits under the Black Lung Benefits Act, 30 U.S.C. § 901 et seq. The Act and implementing regulations, 20 CFR Parts 410, 718, 725 and

727, provide compensation and other benefits to living coal miners who are totally disabled due to pneumoconiosis and their dependents, and surviving dependents of coal miners whose death was due to pneumoconiosis. The Act and regulations define pneumoconiosis, commonly known as black lung disease, as a chronic dust disease of the lungs and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. 30 U.S.C. § 902(b); 20 CFR § 718.201 (2005). In this case, the Claimant, alleges that he istotally disabled by pneumoconiosis.

I conducted a hearing on this claim on January 14, 2004 in Knoxville, Tennessee. All parties were afforded a full opportunity to present evidence and argument, as provided in the Rules of Practice and Procedure before the Office of Administrative Law Judges, 29 CFR Part 18 (2005). At the hearing, the Claimant was the only witness. Transcript ("TR") at 3. Director's Exhibits ("DX") 1-10 and 13-29 and Employer's Exhibits ("EX") 1-4 were admitted into evidence without objection. TR at 6-7. Director's Exhibits 11 and 12 as well as Employer's Exhibits 5-7 were excluded because they exceeded the limitations for the submission of evidence contained in the regulations and the Employer failed to show good cause for their admission.[1] TR at 7-8. The record was held open after the hearing to allow the parties to submit additional evidence and argument. The Employer submitted closing argument, and the record is now closed.

In reaching my decision, I have reviewed and considered the entire record, including all exhibits admitted into evidence, the testimony at hearing and the arguments of the parties.

PROCEDURAL HISTORY

The Miner filed his claim on January 28, 1993. DX 1. The claim was denied by the District Director of the Office of Workers' Compensation Programs ("OWCP") on July 15, 1993, on the grounds that the evidence did not show that the Claimant had pneumoconiosis, or that it was caused by coal mine work, or that the Claimant was totally disabled. The Employer was notified of the claim on July 15, 1993 and filed a controversion on January 21, 1994. By undated letter submitted with the District Director on August 11, 1993, the Claimant stated that he disagreed with the District Director's determination and that he was "appealing the decision."

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[1] Application of the amended regulatory provisions is proper for a claim filed after January 19, 2001. Indeed, the Benefits Review Board has held that the limits are mandatory and cannot be waived by the parties, *Smith v. Martin County Coal Corp.*, 23 B.L.R. 1-___, BRB No. 04-126 BLA, slip op. at 4-5 (Oct. 27, 2004) (unpub.) (to be published pursuant to the BRB's January 26, 2005 Order). However, on closer examination, I find that the Miner's original claim, filed on January 28, 1993, remains viable for reasons set forth later in this *Decision*. Thus, the evidentiary limitations at 20 C.F.R. § 725.414 (2005) are inapplicable. Nonetheless, I find that it is proper to continue to exclude DX 11 (an interpretation of the July 30, 2002 study by Dr. Wheeler), DX 12 (review of the January 9, 2002 CT-scan by Dr. Wheeler), EX 5 (record review by Dr. Fino), EX 6 (record review by Dr. Castle), and EX 7 (interpretations of the February 5, 2003 study by Drs. Wheeler and Scott and Dr. Scott's interpretation of the July 30, 2002 study) on grounds that this evidence is cumulative and unnecessarily repetitious of the evidence already admitted in this claim. *Woodward v. Director, OWCP,* 991 F.2d 314 (6th Cir. 1993) ("[w]hile the parties have the right to present evidence to defend or support their respective claims, the ALJ must be vested with the discretion to limit the impact of voluminous, duplicative evidence"); *Underwood v. Elkay Mining,Inc.*, 105 F.3d 946 (4th Cir. 1997) ("the APA grants ALJs broad discretion to exclude excessive evidence").

The Claimant retained counsel and, by letter dated January 6, 1994, Claimant's counsel again requested a hearing. Rather than forwarding the claim to this Office for a hearing, the District Director scheduled an informal conference for May 11, 1994. As a result of the conference, on June 14, 1994 the District Director issued a *Proposed Decision and Order Memorandum of Conference* denying benefits. In particular, the District Director concluded that: (1) the miner's claim was timely filed; (2) he had one dependent, his wife Linda, for purposes of augmentation of benefits; (3) the miner established 16 years of coal mine employment; and (4) Allied Coal Corporation, as well as its parent company, West Coal Corporation, would be liable for the payment of any benefits. With regard to the medical entitlement issues, however, the District Director concluded that the Claimant failed to establish any element of entitlement. No further action was taken with regard to the claim.

The miner filed a second claim form on April 15, 2002. DX 3. On June 27, 2003, the District Director issued a *Proposed Decision and Order – Denial of Benefits* on grounds that, although the Claimant demonstrated that he suffered from coal workers' pneumoconiosis, he did not establish that he was totally disabled due to the disease. DX 24. By letter dated July 23, 2003, the Claimant requested a hearing. DX 26. The claim was referred to this Office for adjudication on September 9, 2003. DX 29.

STATUS OF THE CLAIM

The District Director and Employer have properly set forth the standard for review of a subsequent claim under 20 C.F.R. § 725.309. However, close examination of the record reveals that the District Director did not properly act on Claimant's timely hearing request in the original 1993 claim. The amended regulations at 20 C.F.R. § 725.418(c) (2004) provide that the District Director must forward the claim file to this Office if there is any hearing request, even if such a request is "premature." In its comments to the amended regulations, the Department specifically states that "[i]n the case of a claimant who has previously requested a hearing, the district director will forward the case if he has denied benefits." 65 Fed. Reg. 79997 (Dec. 20, 2000).

Notably, the Third Circuit interpreted the regulations in effect at the time of the District Director's 1993 denial in this claim as also requiring that the claim be forwarded to this Office once a hearing request is submitted, even if the request is "premature." *Plesh v. Director, OWCP*, 71 F.3d 103 (3rd Cir. 1995). The court held that any informal communication requesting a hearing triggered the District Director's duty to forward all contested and uncontested issues to this Office for adjudication and, even if the hearing request was "premature," the party's right to a hearing was preserved and it was unnecessary to file a second hearing request.

Here, the District Director clearly denied the 1993 claim for benefits and the Claimant filed a timely hearing request. As opposed to forwarding the claim at that point, the District Director convened an informal conference and again denied benefits. At the time, the District Director declined to forward the claim to this Office absent a second hearing request by the Claimant, which was never submitted.

Plesh reasonably interprets the regulatory language in effect at the time of the District Director's processing of the Miner's 1993 claim. Moreover, the *Plesh* holding is consistent with

the Department's current position that a party has a right to have a claim forwarded to this Office, regardless of when it submits a hearing request to the District Director.

The Claimant's letter, which was submitted on August 11, 1993, effectively triggered the District Director's obligation to forward his original claim to this Office for adjudication at that time. Convening an informal conference after receipt of the letter did not alleviate the District Director's obligation in this regard. It is unfortunate that more than ten years passed before the record in this matter was forwarded to this Office. As a result, I find that the Claimant's January 28, 1993 claim is open and viable and this matter will be processed in accordance with the regulations in effect at the time the claim was filed. Notably, the provisions at 20 C.F.R. §§ 718.2 and 725.2 (2005) provide that certain amended regulatory provisions are also applicable to this claim.

APPLICABLE STANDARDS

This case relates to a claim filed on January 28, 1993. Because the claim at issue was filed after March 31, 1980, the regulations at 20 CFR Part 718 apply. 20 CFR § 718.2 (2005). In order to establish entitlement to benefits under Part 718, the Claimant must establish that he suffers from pneumoconiosis, that his pneumoconiosis arose out of his coal mine employment, and that his pneumoconiosis is totally disabling. 20 CFR §§ 718.1, 718.202, 718.203 and 718.204 (2005).[2]

ISSUES

The issues listed as contested by the Employer and the Director on the CM-1025 are:

1. Whether the claim was timely filed.

2. Whether the Claimant worked as a "miner."

[2] Parts 718 (standards for award of benefits) and 725 (procedures) of the regulations underwent extensive revisions effective January 19, 2001. 65 Fed. Reg. 79920 et seq. (2000). The Department of Labor has taken the position that as a general rule, the revisions to Part 718 should apply to pending cases because they do not announce new rules, but rather clarify or codify existing policy. See 65 Fed. Reg. at 79949-79950, 79955-79956 (2000). Changes in the standards for administration of clinical tests and examinations, however, would not apply to medical evidence developed before January 19, 2001. 20 CFR § 718.101(b) (2005). The new rules specifically provide that some revisions to Part 725 apply to pending cases, while others do not; for a list of the revised sections which do **not** apply to pending cases, see 20 CFR § 725.2(c) (2005). The U.S. District Court for the District of Columbia upheld the validity of the new regulations in *National Mining Association v. Chao*, 160 F.Supp.2d 47 (D.D.C. 2001). However, the Court of Appeals affirmed in part, reversed in part, and remanded the case. *National Mining Association v. Department of Labor*, 292 F.3d 849 (D.C. Cir. 2002) (Upholding most of the revised rules, finding some could be applied to pending cases, while others should be applied only prospectively, and holding that one rule empowering cost shifting from a claimant to an employer exceeded the authority of the Department of Labor). On December 15, 2003, the Department of Labor promulgated revisions to 20 CFR §§ 718.2, 725.2 and 725.459 implementing the Circuit Court's opinion. 68 Fed. Reg. 69930 et seq. (2003). Accordingly, I will apply only the sections of the newly revised version of Parts 718 and 725 that the court did not find impermissibly retroactive. In this Decision and Order, the "old" rules applicable to this case will be cited to the 2000 edition of the Code of Federal Regulations; the "new" rules will be cited to the 2005 edition.

3. Whether the Claimant worked in the mines after 1969.

4. Whether he has pneumoconiosis as defined by the Act and the regulations.

5. Whether his pneumoconiosis arose out of coal mine employment.

6. Whether he is totally disabled.

7. Whether his disability is due to pneumoconiosis.

8. The number of his dependents for purposes of augmentation.

9. Whether the named Employer is the Responsible Operator.

10. Whether the evidence establishes that one of the applicable conditions of entitlement has changed pursuant to 20 CFR § 725.309 (2005).

DX 18 and 29. The Employer also reserved its right to challenge the statute and regulations. DX 18 and 19.

At the hearing, the Employer withdrew issues listed as contested on the CM-1025 except for the following: (1) whether the claim was timely filed; (2) whether the miner suffers from pneumoconiosis; (3) whether his pneumoconiosis arose out of coal mine employment; (4) whether the miner is totally disabled; (5) whether his total disability is due to pneumoconiosis; and (6) the number of dependents for purposes of augmentation of benefits.[3] TR at 5; DX 29.

The Employer did not contest the District Director's finding of 16.5 years of verifiable coal mine employment. DX 29. The Employer also agreed that it is properly designated as the responsible operator in this claim. TR at 5.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and the Claimant's Testimony

Generally

The Claimant testified that, at the time of the hearing, he was 66 years old and he stands six feet tall. TR 10 and 16. He stated that he worked in the coal mines for 17 years ending "about 11 year(s) ago" when the mine was closed. TR 11 and 15. The Claimant last worked as a roof bolter for Key Mining. TR 14.

[3] Although the Employer also continues to challenge whether the requirements of 20 C.F.R. § 725.309 are met, I have found that the Miner's January 1993 claim remains viable such that the provisions at § 725.309 are rendered inapplicable. In any event, as I have found that the Claimant has demonstrated that he has pneumoconiosis, and is totally disabled by a pulmonary impairment, he has shown a change in conditions as Section 309 would require.

His last coal mine employment was in Tennessee. TR 14; DX 1 and 4. Therefore this claim is governed by the law of the Sixth Circuit. *Shupe v. Director, OWCP*, 12 B.L.R. 1-200, 1-202 (1989) (en banc). The only other types of jobs held by the Claimant were at a sawmill and "farm work." TR 11-12.

The Claimant testified that he suffers from breathing problems and is able to walk 150 to 200 yards before becoming short of breath. TR 12. He has a flight of 13 stairs to climb at home, but he has "to stand there at the top for a few minutes to . . . get everything to operating right . . .." TR 12. He uses a self-propelled mower to mow his one-half acre yard, but "it takes (him) about two day(s) . . . because I just mow it and rest and mow it and rest . . .." TR 13. While shopping with his wife, the Claimant is only able to walk down two or three aisles at a Wal-Mart before becoming short of breath at which point he goes "back and sit(s) down . . .." TR 13.

The Claimant is currently treated by Dr. Ann Carter, who is a "family doctor." TR 16. She has treated the Claimant for two or three years. TR 16. Within the past five years, the Claimant was hospitalized for lung surgery conducted by Dr. Cai. TR 16-17.

The Claimant has been married to his wife, Linda, for 41 years. TR 14. They do not have any children who are dependent on them for support. TR 14. With regard to his educational background, he completed the second or third grade. TR 15.

Smoking history

In his signed October 26, 2002 answers to the Employer's interrogatories, the Claimant stated that he was "not sure" when he started smoking. DX 21. He noted that he "currently smokes" less than one pack of cigarettes per day. He further stated that he smoked one pack of cigarettes per day in the past, but could not remember the point at which he "cut down" smoking cigarettes.

At the hearing, the Claimant recalled that he started smoking cigarettes at the age of 21 or 22 years and is currently smoking cigarettes. TR 17. He testified that he is not, and has never been, a heavy smoker. TR 17. He states that he has smoked, at most, one-half a pack of cigarettes per day. TR 17. The Claimant also smokes one cigar "a week or something another . . .." TR 17-18.

Duties of last coal mining job

The Claimant prepared a signed statement dated April 10, 2002, wherein he set forth the duties of his last coal mining job as a Bolt Machine Operator. DX 6. He stated the following:

> I drilled holes into the roof. I put bolts of different lengths 3 feet to 6 feet long with steel plates into the roof. This supported the roof to keep (sic). I used the hydraulic drill bolt machine. I drill through all types of rocks, coal for the bolts. I stayed on my knees and sitting. I followed behind the miner making cuts.

The Claimant also recalled that he would "crawl" approximately 100 yards per day.

Timeliness

As previously noted, the Miner's January 28, 1993 claim continues to be viable. Under 20 CFR § 725.308(a), a claim of a living miner is timely filed if it is filed "within three years after a medical determination of total disability due to pneumoconiosis" has been communicated to the miner. 20 CFR § 725.308(c) creates a rebuttable presumption that every claim for benefits is timely filed. This statute of limitations does not begin to run until a miner is actually diagnosed by a doctor, regardless of whether the miner believes he has the disease earlier. *Tennessee Consolidated Coal Company v. Kirk*, 264 F.3d 602 (6th Cir. 2001).

In this claim, there is no medical opinion that constitutes a sufficient basis upon which to commence the limitations period at § 725.308 to run. Dr. Bruton's March 1993 report provides only a diagnosis of coal workers' pneumoconiosis, not total disability. Dr. Gaziano, by report dated March 24, 1994, concludes that the Miner suffers from coal workers' pneumoconiosis and is totally disabled, but he does not specifically find that the Miner's total disability is due to coal workers' pneumoconiosis. Dr. Cai's 2002 treatment notes and reports contain neither a diagnosis of coal worker's pneumoconiosis nor total disability. Dr. Crater's July 2002 report contains a finding that the Miner suffers from an impairment due, in part, to coal workers' pneumoconiosis, but he specifically noted that the extent of the Miner's impairment was "difficult to assess" due to invalid pulmonary function testing. Dr. Jarboe, in his February 2003 report, diagnosed the presence of coal workers' pneumoconiosis and a totally disabling respiratory impairment, but he concluded that the Claimant's pneumoconiosis did not contribute to his impairment. Finally, Dr. Jarvis concluded in his November 2003 that the Miner did not suffer from coal workers' pneumoconiosis and did not have a totally disabling respiratory or pulmonary impairment.

Consequently, I find that none of the reports of record contains a diagnosis of total disability due to coal worker' pneumoconiosis communicated to the Miner that would be sufficient to commence the limitations period set forth at § 725.308 to run. The Miner's claim is timely filed.

Medical Evidence

Chest X-rays

Chest x-rays may reveal opacities in the lungs caused by pneumoconiosis and other diseases. Larger and more numerous opacities result in greater lung impairment. The following table summarizes the x-ray findings available in this case.

The existence of pneumoconiosis may be established by chest x-rays classified as category 1, 2, 3, A, B, or C according to ILO-U/C International Classification of Radiographs. Small opacities (1, 2, or 3) (in ascending order of profusion) may classified as round (p, q, r) or irregular (s, t, u), and may be evidence of "simple pneumoconiosis." Large opacities (greater than 1 cm) may be classified as A, B or C, in ascending order of size, and may be evidence of "complicated pneumoconiosis." A chest x-ray classified as category "0," including subcategories 0/-, 0/0, 0/1, does not constitute evidence of pneumoconiosis. 20 CFR §

718.102(b) (2005). Any such readings are therefore included in the "negative" column. X-ray interpretations which make no reference to pneumoconiosis, positive or negative, given in connection with medical treatment or review of an x-ray film solely to determine its quality, are listed in the "silent" column.

Physicians' qualifications appear after their names. Qualifications have been obtained where shown in the record by curriculum vitae or other representations, or if not in the record, by judicial notice of the lists of readers issued by the National Institute of Occupational Safety and Health (NIOSH).[4] If no qualifications are noted for any of the following physicians, it means that either they have no special qualifications for reading x-rays, or I have been unable to ascertain their qualifications from the record or the NIOSH lists. Qualifications of physicians are abbreviated as follows: B= NIOSH certified B reader; and BCR= board-certified in radiology. Readers who are board-certified radiologists and/or B readers are classified as the most qualified. See *Mullins Coal Co. v. Director, OWCP*, 484 U.S. 135, 145 n. 16 (1987); *Old Ben Coal Co. v. Battram*, 7 F.3d 1273, 1276 n.2 (7th Cir. 1993). B readers need not be radiologists.

X-ray interpretations appear on the following chart:

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
DX 1 03-17-93	Bruton No radiological qualifications 1/1, s (all six lung zones)		Sargent B, BCR The study is unreadable due to over-exposure, poor contrast, lack of sharp detail, and fogging. Therefore, he cannot "evaluate accurately for perfusion or possible small opacities."

[4]NIOSH is the federal government agency that certifies physicians for their knowledge of diagnosing pneumoconiosis by means of chest x-rays. Physicians are designated as "A" readers after completing a course in the interpretation of x-rays for pneumoconiosis. Physicians are designated as "B" readers after they have demonstrated expertise in interpreting x-rays for the existence of pneumoconiosis by passing an examination. Historical information about physician qualifications appears on the U.S. Department of Health and Human Services, List of NIOSH Approved B Readers with Inclusive Dates of Approval [as of] June 7, 2004, found at http://www.oalj.dol.gov/public/blalung/refrnc/bread3_07_04.htm. Current information about physician qualifications appears on the CDC/NIOSH, NIOSH Certified B Readers List found at http://www.cdc.gov/niosh/topics/chestradiography/breader-list.html.

Date of X-ray	Read as Positive for Pneumoconiosis	Read as Negative for Pneumoconiosis	Silent as to the Presence of Pneumoconiosis
DX1 04-27-93	Bruton No radiological qualifications 1/1, t	Sargent B, BCR Noted marginal film quality. Questioned presence of smoking history. Found no parenchymal or pleural abnormalities consistent with pneumoconiosis.	
DX 1 03-03-94	Gaziano B 1/1, t/q (five lung zones)	Sargent B, BCR 0/1, s/s (lower 4 zones). Questioned smoking history. Found parenchymal abnormalities consistent with pneumoconiosis.	
DX 10, EX 1 07-30-02	Crater No radiological qualifications. 1/2, s/s (all six lung zones). Also noted "[d]ense scar/mass in right apex with pleural thickening."	Wiot B, BCR No ILO-U/C classification provided. However, in accompanying written report he stated there was "no evidence of coal workers' pneumoconiosis."	Goldstein B Film quality reading only. Read film as quality 1.
DX 13 02-05-03		Jarboe B 0/1, s/q (upper 4 lung zones)	
EX 2 11-12-03		Jarvis No radiological qualifications No ILO-U/C classification provided. However, in written report he stated that the study "does not show evidence of coal workers' pneumoconiosis." He further identified a "right upper lobe scar."	

Biopsies

Biopsies may be the basis for a finding of the existence of pneumoconiosis. A finding of anthracotic pigmentation is not sufficient, by itself, to establish pneumoconiosis. 20 CFR § 718.202(a)(2) (2005). Section 718.106(a) provides that a biopsy report shall include a detailed gross macroscopic and microscopic description of the lungs or visualized portion of a lung. If a surgical procedure was performed to obtain a portion of a lung, the evidence should include a copy of the surgical note and the pathology report. The Benefits Review Board has held, however, that the quality standards are not mandatory and failure to comply with the standards goes only to the reliability and weight of the evidence. *Dillon v. Peabody Coal Co*., 11 B.L.R. 1-113, 1-114 (1988); *see Dagnan v. Black Diamond Coal Mining Co*., 994 F.2d 1536, 1540-1541 (11th Cir. 1992). Section 718.106(c) provides that "[a] negative biopsy is not conclusive evidence that the miner does not have pneumoconiosis. However, where positive findings are obtained on biopsy, the results will constitute evidence of the presence of pneumoconiosis."

There was one biopsy conducted on February 25, 2002 to determine the etiology of a growing mass in the Claimant's right upper lung. DX 1 and 9. The Miner's treating physician, Dr. Tung H. Cai conducted the biopsy because he observed a 7 millimeter nodule in the left apex of the Miner's lung that was "very worrisome for malignancy." DX 1. He concluded that the right upper lung mass was the product of "chronic inflammation," but there was no evidence of a malignancy. DX 9.

Dr. Rebecca L. Foust, who is board-certified in anatomic and clinical pathology and has a subspecialty in cytopathology, reviewed the biopsy tissue and issued a report of her findings on February 27, 2002. DX 1. In the lymph nodes, Dr. Foust found evidence of histocytosis, anthracosis, and anthracotic pigment. However, there was no evidence of metastatic carcinoma. In the right lower lobe, Dr. Foust noted interstitial fibrosis, chronic inflammation, emphysematous change, and "a dip-like reaction." With regard to the upper lobe mass, Dr. Foust noted the presence of "dense fibrotic nodules with surrounding fibrohistiocytic spindle cell proliferation with anthracotic pigment and foreign material." Dr. Foust further found "extensive hyalinized nodularity in the lung, especially in an area under the pleura, and "[t]he findings are consistent with what is found in certain pneumoconiosis, including silicosis and coal workers' pneumoconiosis." Dr. Foust also stated that there was "emphysematous change throughout much of the tissue." She noted "abundant anthracotic pigment" in the Miner's lungs, but did not find evidence of carcinoma.

As a result, the biopsy report contains observations of anthracosis and "extensive hyalinized nodularity" consistent with silicosis and coal workers' pneumoconiosis. It supports a finding that the Claimant suffers from the disease.

CT Scans

CT scans may be used to diagnose pneumoconiosis and other pulmonary diseases. The regulations provide no guidance for the evaluation of CT scans. They are not subject to the specific requirements for evaluation of x-rays, and must be weighed with other acceptable

medical evidence. *Melnick v. Consolidation Coal Co*., 16 B.L.R. 1-31, 1-33-1-34 (1991). The record in this case contains reports of a January 9, 2002 CT scan of the Claimant's chest.

The CT-scan was conducted at the request of Dr. Tung Cai, one of the Claimant's treating physicians. DX 9. Dr. Cai noted that the scan demonstrated "some associated parenchymal changes" of the right upper lung mass. Dr. Cai's radiological qualifications, if any, are not in the record.

Dr. Jerome Wiot, a board-certified radiologist and B-reader, reviewed the CT-scan and issued a report on February 19, 2003. DX 13. He concluded that it was not a reliable source of medical data in determining whether the Miner suffers from pneumoconiosis. In particular, Dr. Wiot noted that the "[l]ung windows were not submitted" with the CT-scan and that "[e]valuation of the chest CT for coal workers' pneumoconiosis requires lung windows for adequate evaluation." Given Dr. Wiot's superior radiological qualifications, I find that the CT-scan is unreliable for purposes of assessing the presence or absence of pneumoconiosis.

Pulmonary Function Studies

Pulmonary function studies are tests performed to measure obstruction in the airways of the lungs and the degree of impairment of pulmonary function. The greater the resistance to the flow of air, the more severe the lung impairment. The studies range from simple tests of ventilation to very sophisticated examinations requiring complicated equipment. The most frequently performed tests measure forced vital capacity (FVC), forced expiratory volume in one-second (FEV_1) and maximum voluntary ventilation (MVV).

The following chart summarizes the results of the pulmonary function studies available in this case. "Pre" and "post" refer to administration of bronchodilators. If only one figure appears, bronchodilators were not administered. In a "qualifying" pulmonary study, the FEV_1 must be equal to or less than the applicable values set forth in the tables in Appendix B of Part 718, and either the FVC or MVV must be equal to or less than the applicable table value, or the FEV_1/FVC ratio must be 55% or less. 20 CFR § 718.204(b)(2)(i) (2005).

Ex. No. Date Physician	Age Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 03-17-93 Bruton	55 72"	2.84	2.84	100%	62	No	Fair cooperation and good comprehension noted.

[5] The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1-221, 1-223 (1983); *Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109, 114, 116 (4th Cir. 1995). As there is a variance in the recorded height of the miner from 70" to 72", I have taken the mid-point (71") in determining whether the studies qualify to show disability under the regulations.

Ex. No. Date Physician	Age Height[5]	FEV_1 Pre-/ Post	FVC Pre-/ Post	FEV_1/ FVC Pre-/ Post	MVV Pre-/ Post	Qualify?	Physician Impression
DX 1 03-03-94 Gaziano	56 70”	3.32	4.21	79%	85	No	
DX 10 07-30-02 Crater	65 72”	1.35	1.69	80%	38	Yes	Fair cooperation and comprehension noted on the test form. However, in his written report, Dr. Crater stated that the test was invalid due to “poor” effort. By report dated August 27, 2002, Dr. John Michos validated the study, but noted suboptimal MVV performance (DX 10). Drs. Jarboe and Jarvis concluded that the study was invalid due to poor cooperation (EX 3 at 14; EX 4 at 12).
DX 13 02-20-03 Jarboe	65 72”	3.19	4.26	75%	69	No	
EX 2 11-12-03 Jarvis	66 72”	2.77 3.27	3.08 4.38	89% 75%	-- --	No No	

Arterial Blood Gas Studies

Blood gas studies are performed to measure the ability of the lungs to oxygenate blood. A defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. The blood sample is analyzed for the percentage of oxygen (PO_2) and the percentage of carbon dioxide (PCO_2) in the blood. A lower level of oxygen (O_2) compared to carbon dioxide (CO_2) in the blood indicates a deficiency in the transfer of gases through the alveoli which may leave the miner disabled.

The following chart summarizes the arterial blood gas studies available in this case. A "qualifying" arterial gas study yields values which are equal to or less than the applicable values set forth in the tables in Appendix C of Part 718. If the results of a blood gas test at rest do not satisfy Appendix C, then an exercise blood gas test can be offered. Tests with only one figure represent studies at rest only. Exercise studies are not required if medically contraindicated. 20 CFR § 718.105(b) (2000).

Exhibit Number	Date	Physician	PCO_2 at rest/ exercise	PO_2 at rest/ exercise	Qualify?	Physician Impression
DX 1	03-17-93	Bruton	41.8 43.1	79.4 83.7	No No	
DX 10	07-30-02	Crater	40.2 44.1	83.8 73.2	No No	
DX 13	02-05-03	Jarboe	43.6 36.0	88.0 72.6	No No	

Medical Opinions

Medical opinions are relevant to the issues of whether the miner has pneumoconiosis, whether the miner is totally disabled, and whether pneumoconiosis caused the miner's disability. A determination of the existence of pneumoconiosis may be made if a physician, exercising sound medical judgment, notwithstanding a negative x-ray, finds that the miner suffers from pneumoconiosis as defined in § 718.201. 20 CFR §§ 718.202(a)(4) (2005). Thus, even if the x-ray evidence is negative, medical opinions may establish the existence of pneumoconiosis. *Taylor v. Director, OWCP*, 9 B.L.R. 1-22 (1986). The medical opinions must be reasoned and supported by objective medical evidence such as blood gas studies, electrocardiograms, pulmonary function studies, physical performance tests, physical examination, and medical and work histories. 20 CFR § 718.202(a)(4) (2005). Where total disability cannot be established by pulmonary function tests, arterial blood gas studies, or cor pulmonale with right-sided heart failure, or where pulmonary function tests and/or blood gas studies are medically contraindicated, total disability may be nevertheless found, if a physician, exercising reasoned medical judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a miner's respiratory or pulmonary condition prevents or prevented the miner from engaging in employment, i.e., performing his usual coal mine work or comparable and gainful work. 20 CFR § 718.204(b)(2)(iv) (2005). With certain specified exceptions not applicable here, the cause or causes of total disability must be established by means of a physician's documented and reasoned report. 20 CFR § 718.204(c)(2) (2005). The record contains the following medical opinions relating to this case.

The Claimant was examined and tested on behalf of the Department of Labor by Dr. Charles W. Bruton, who issued a report on March 17, 1993. DX 1. Dr. Bruton noted approximately 15 years of coal mine employment ending in 1991 and that the Claimant never smoked. A chest x-ray was interpreted as demonstrating Category 1 pneumoconiosis. Examination of the lungs revealed the presence of rales. Ventilatory testing was considered by

Dr. Bruton as invalid despite the fact that the Claimant "appeared to give good effort." Blood gas testing yielded evidence of mild hypoxemia at rest with an "an appropriate rise" in oxygen levels after exercise. However, Dr. Bruton noted that the Miner complained of shortness of breath with "moderate activity such as brisk walking or climbing hills." Moreover, he noted that the "[r]ecent treadmill test showed (the Claimant's) exercise tolerance to be (one-third) of predicted, (but the) heart was reportedly OK." Dr. Bruton diagnosed the presence of simple coal workers' pneumoconiosis, but concluded that the Miner did not suffer from an impairment. Dr. Bruton's qualifications are not in the record. DX 1.

The Claimant was examined and tested by Dr. Dominic Gaziano, a physician of Claimant's choice, who issued a report on March 24, 1994. DX 1. Dr. Gaziano noted a 17 year coal mine employment history as well as the fact that the Claimant "smoked cigars on social occasions for three years." He stated that the Claimant last worked in the mines as a roof bolter and machine operator. Dr. Gaziano noted that the Claimant complained of a productive cough, which had been present for three years, and that the Miner "gets short of breath with very little activity, walking, climbing stairs and other physical activities." Examination of the lungs revealed "rales in both bases which did not clear with cough." The heart was "regular, without murmur, thrill, gallop, or cardiac enlargement." There was no clubbing of the fingers. A chest x-ray was interpreted as demonstrating Category 1 pneumoconiosis with "irregular and rounded opacities throughout both lungs." Ventilatory testing yielded non-qualifying results. The Miner's diffusing capacity for carbon monoxide was "moderately reduced." Dr. Gaziano concluded that the Claimant suffers from coal workers' pneumoconiosis and that he had a "moderate degree of pulmonary functional impairment" as evidenced "by the moderate reduction in his diffusing capacity." He opined that the Miner could not "continue work in the underground mines due to his pulmonary functional impairment." He did not specifically state whether the Miner's totally disabling respiratory impairment was due to his pneumoconiosis. Dr. Gaziano is board-certified in internal medicine and pulmonary diseases and he is a B-reader. DX 1.

Certain treatment notes and reports are also in the record. DX 9. Dr. Tung H. Cai conducted a physical examination at the Claimant's request and issued a report on January 31, 2002. A chest x-ray revealed that a mass in the Miner's right upper lung had been "increasing in size" and Dr. Cai recommended a biopsy to ascertain its cause. A CT-scan dated January 9, 2002 revealed "some associated parenchymal changes" of the right upper lung mass. Dr. Cai noted that the Claimant worked as a coal miner for an unspecified length of time and that he had smoked one pack of cigarettes per day for 12 years. Dr. Cai further stated that the Claimant continued to smoke cigarettes. He noted that the Miner did not complain of chest pain. Examination of the lungs revealed that they were "clear to auscultation bilaterally." Dr. Cai offered no opinion whether the Miner suffered from coal workers' pneumoconiosis or was totally disabled. DX 9.

The Claimant was examined and tested on behalf of the Department of Labor by Dr. Glenn D. Crater, who issued a report on July 30, 2002. DX 10. Dr. Crater noted a 17 year history of coal mine employment as well as that the Claimant started smoking cigarettes at the age of 25 years at the rate of one-half a pack of cigarettes per day. The Claimant continued to smoke cigarettes at the time of his examination. The lungs were "clear" on examination and

examination of the heart yielded normal results. A chest x-ray was interpreted as demonstrating Category 1 pneumoconiosis. Ventilatory testing was deemed invalid due to "poor effort," but Dr. Crater noted that it indicated the presence of a mixed obstructive and restrictive impairment. Blood gas testing yielded non-qualifying values. Dr. Crater noted that the Miner had a "mildly elevated" carboxyhemoglobin level. The EKG produced evidence of "normal sinus rhythm." Dr. Crater diagnosed the presence of "interstitial lung disease" and chronic obstructive pulmonary disease. He determined that the conditions were caused by the Claimant's mining and smoking histories. With regard to the extent of the Miner's impairment, Dr. Crater stated that it was:

> [d]ifficult to assess due to (the Claimant's) inconsistent effort on (pulmonary function tests). Suggests mild to moderate impairment.

He further stated that the Miner's impairment was "completely" due to his smoking and mining-induced respiratory diseases. Dr. Crater's qualifications are not in the record. DX 10.

At the Employer's request, Dr. Thomas M. Jarboe examined and tested the Miner on February 4, 2003, conducted a review of certain medical records, and issued a report on February 20, 2003. DX 13. Dr. Jarboe reported 17 years of coal mine employment, where the Claimant last worked as a roof bolter, as well as a history of smoking one-half a pack of cigarettes per day since the Claimant was in his "late teens or early 20s." He stated that the Claimant was currently smoking three to four cigarettes per day. Dr. Jarboe noted that the Miner complained of shortness of breath while walking on level ground for one block and that he suffers from dyspnea while using a self-propelled mower. The Claimant reported that these symptoms had been present for ten years. Examination of the lungs revealed "good air entry into all lung zones with no rales or wheezes identified." Further, examination of the heart produced evidence of "regular rhythm without murmur or gallop." Dr. Jarboe did not observe clubbing of the Miner's fingers. He noted that the Miner was on a prescription inhaler called Atrovent. A chest x-ray was interpreted as demonstrating Category 0/1 pneumoconiosis**.** Ventilatory testing produced normal values without evidence of significant obstruction or restriction. There was, however, evidence of a "minimal reduction of total lung capacity." The Miner's diffusing capacity was "moderately lowered." Resting blood gas testing was normal, but there was a "significant fall in oxygen tension with exercise." The Miner's carboxyhemoglobin level was at the "upper limit of normal."

On review of medical records surrounding the Claimant's February 2002 lung biopsy, Dr. Jarboe noted that the pathologist, Dr. Foust, observed interstitial fibrosis, emphysematous changes, and desquamative interstitial pneumonia (DIP). Dr. Jarboe opined the following:

> Coal dust inhalation can cause interstitial fibrosis but this is unusual. When it does so, there usually is association with anthracotic pigmentation. It is not clear in the pathological description whether or not the interstitial fibrosis is associated with coal dust.

Dr. Jarboe stated that the "emphysematous changes which are present have likely been caused by Mr. Lowe's long history of smoking cigarettes." He noted that the Claimant has a "significant

impairment of gas exchange caused by interstitial lung disease, emphysema, and desquamative interstitial pneumonia all unrelated to coal dust exposure." DX 13.

Dr. Jarboe diagnosed the presence of simple coal workers' pneumoconiosis and chronic bronchitis based on Dr. Foust's pathological description of the Miner's lung tissue, which included "extensive hyalinized nodularity in the lung" and "abundant birefringent material." Thus, based on the pathological findings and a chest x-ray, Dr. Jarboe concluded that it was "reasonable" to find the presence of simple coal workers' pneumoconiosis. DX 13.

Dr. Jarboe stated that there was inadequate evidence to suggest that the mass in the Miner's right upper lung was complicated pneumoconiosis, "Dr. Foust describes the findings as showing 'extensive hyalinized nodularlity'" and, in Dr. Jarboe's opinion, this description is more compatible with a diagnosis of simple coal workers' pneumoconiosis. DX 13.

Dr. Jarboe concluded that the Miner suffered from a totally disabling respiratory impairment. Although the ventilatory and blood gas studies produced normal values, the Miner's diffusing capacity was moderately reduced and "[t]his is associated with a significant fall in oxygen tension with exercise" such that the Claimant would not be able to perform his last job as a roof bolter. Dr. Jarboe opined that the cause of the impairment was interstitial lung disease, emphysema, and DIP, which are conditions unrelated to coal dust exposure. He noted that, generally, coal workers' pneumoconiosis produces either normal or mildly reduced diffusing capacity values. Dr. Jarboe opined that "[i]t would be very unusual to have a diffusion capacity of 40% caused by simple coal workers' pneumoconiosis." DX 13.

Dr. Jarboe is board-certified in internal medicine and pulmonary diseases and he is a B-reader. DX 13.

Dr. Jarboe was deposed on January 12, 2004. EX 3. He testified that Atrovent, which is the Claimant's prescription inhaler, is "most commonly used to treat chronic obstructive pulmonary disease and specifically the type of chronic obstructive pulmonary disease that results from smoking, for example, emphysema, chronic bronchitis." EX 3 at 8-9. Dr. Jarboe further noted that the medication could be used in the treatment of asthma. EX 3 at 9.

With regard to the Miner's smoking history, Dr. Jarboe recalled that the Claimant advised that he was "never a heavy smoker" and that he "used less than a half a pack of cigarettes per day." EX 3 at 9. However, Dr. Jarboe also noted that the patient's history form, which was supposedly completed by the Claimant, revealed a smoking history of one pack of cigarettes per day. EX 3 at 9. As a result, Dr. Jarboe assumed that the Miner smoked one pack of cigarettes per day. EX 3 at 9.

Dr. Jarboe recalled that the Claimant last worked as a roof bolter in 1990, after 17 years of coal mine employment. EX 3 at 10. Because of a drop in the Miner's oxygen tension on exercise, Dr. Jarboe reiterated that the Miner was totally disabled from his last job as a roof bolter because "it would be difficult to do sustained hard manual labor with an abnormality in (his) lungs that would cause such a fall in oxygen tension." EX 3 at 16.

Dr. Jarboe emphasized that Dr. Foust's pathology report revealed findings consistent with DIP, which is "a very specific type of inflammatory lesion in the lung that is seen only in cigarette smokers." EX 3 at 11. Again, Dr. Jarboe stated that Dr. Foust made no findings to support a diagnosis of complicated pneumoconiosis:

> She made measurements of several portions of the lung tissue that were removed, but she never specifically came down and said, here is a nodule that's two centimeters in diameter.

EX 3 at 12. Moreover, Dr. Jarboe noted that Dr. Foust never observed a "large nodule that was anthracotic." EX 3 at 12.

Dr. Jarboe also noted that "[e]mphysema can be caused by coal dust exposure, but (one) would expect that to be intimately associated with a lot of dust retention, and (Dr. Foust) doesn't specifically describe that, she doesn't say the emphysema is associated with coal dust deposition, per se . . .." EX 3 at 13. As a result, Dr. Jarboe concludes that the Miner's emphysema is most likely related to his history of smoking. EX 3 at 18. Similarly, he reiterated that DIP is smoking induced and would cause the drop the oxygen tension experienced by the Claimant while exercising. EX 3 at 18. Finally, findings of non-specific fibrosis would contribute to a fall in the Miner's oxygen tension, but the cause of the fibrosis was not clear from Dr. Foust's observations. EX 3 at 18. Dr. Jarboe reiterated that the smoking induced emphysema and DIP as well as the interstitial fibrosis of unknown etiology caused a drop in the Miner's oxygen tension on exercise and "would be more likely to do so than simple pneumoconiosis." EX 3 at 19. Indeed, Dr. Jarboe opined that mild simple pneumoconiosis "as a rule does not cause desaturation or drop in oxygen tension on exercise." EX 3 at 19. Dr. Jarboe did state that simple coal workers' pneumoconiosis may progress in the absence of continued exposure. EX 3 at 27.

On request of the Employer, Dr. David A. Jarvis examined and tested the Miner, reviewed certain medical records, and issued a report on November 12, 2003. EX 2. Dr. Jarvis reported a 15 year history of coal mine employment as well as an on-going habit of smoking one pack of cigarettes per day. He noted that the Miner complained of shortness of breath "sometimes" but that he "remains quite active with no impairment of his normal daily activities." Dr. Jarvis concluded that Dr. Foust's pathology report was "relatively nonspecific" and revealed the presence of "fibrosis and inflammatory change, but no evidence of active infection or malignancy." On examination, the Miner had "excellent chest expansion" and the lungs "were completely clear." There were no wheezes, rales, rubs, or rhonchi. Cardiac examination revealed "regular rhythm with no murmur, gallop or rub." Ventilatory testing produced normal values, "without evidence of obstruction or restriction." The EKG was "within normal limits." Dr. Jarvis noted the presence of a "scar" in the right upper lobe on a chest x-ray, but rendered no other findings. He concluded that the Miner did not suffer from any "significant pulmonary impairment" and that there was no chest x-ray evidence of coal workers' pneumoconiosis. Dr. Jarvis found that, after a biopsy, the cause of the mass in the right upper lobe was unclear, but it was "possibly related to coal dust exposure." He concluded that his examination of the Miner was "[o]therwise normal" with no evidence of "any pulmonary impairment or disability." Dr. Jarvis is board-certified in internal medicine and pulmonary diseases. EX 2.

Dr. Jarvis was deposed on January 9, 2004. EX 4. He stated that he was engaged in private practice of pulmonary medicine. EX 4 at 4.

Dr. Jarvis reiterated that the Claimant worked in the mines from 1976 until 1991, which was a "significant" period of time. EX 4 at 6. He further stated that the Miner had a "significant" history of smoking one pack of cigarettes per day. EX 4 at 6. However, Dr. Jarvis concluded that the Claimant's respiratory symptoms were "[v]ery scant" as the Miner complained of being occasionally short of breath, but that he was "very active and ha[d] no interference with his activities of daily living." EX 4 at 6-7.

Dr. Jarvis noted that the Claimant's prescription inhaler, Combivent, is generally prescribed for a person suffering from asthma, which is "a spasm of the airway which causes a wheezing sound and is usually attributed to smoking." EX 4 at 7.

He further testified that Dr. Foust's pathology report was "pretty nonspecific . . . just showing inflammatory tissue." EX 4 at 8. Dr. Jarvis opined the following:

> People with zero exposure to coal dust could have an identical biopsy to that that was taken out of this particular patient. And there's no respiratory impairment. This man is not impaired. He has normal testing. Even let's say he had coal workers' pneumoconiosis, which I strongly believe he does not, there is zero impairment based on multiple tests.

EX 4 at 14.

Dr. Jarvis recalled that his examination of the Miner revealed a normal respiratory function based on the Claimant's normal oxygen level while breathing room air at rest as well as after walking "up and down the hall several times." EX 4 at 9. Further, he stated that he would not rely on a single diffusing capacity study to assess disability as did Dr. Jarboe because "[t]he diffusion capacities are very variable and often unreliable" such that he would "repeat (the test) once or twice" before basing a diagnosis on the data. EX 4 at 13.

Existence of Pneumoconiosis

The regulations define pneumoconiosis broadly:

> (a) For the purpose of the Act, "pneumoconiosis" means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or "clinical", pneumoconiosis and statutory, or "legal", pneumoconiosis.
>
> (1) Clinical Pneumoconiosis. "Clinical pneumoconiosis" consists of those diseases recognized by the medical community as pneumoconioses, i.e., the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal

workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silico-tuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. "Legal pneumoconiosis" includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease "arising out of coal mine employment" includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, "pneumoconiosis" is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 CFR § 718.201 (2005). In this case, reports of Drs. Foust, Jarboe, and Crater indicate that the Claimant has been diagnosed with chronic obstructive pulmonary disease and emphysema, which can be encompassed within the definition of legal pneumoconiosis. Ibid.; *Richardson v. Director, OWCP*, 94 F.3d 164 (4th Cir. 1996); *Warth v. Southern Ohio Coal Co*., 60 F.3d 173 (4th Cir. 1995). However, only chronic obstructive pulmonary disease or emphysema caused by coal dust constitutes legal pneumoconiosis. *Eastover Mining Co. v. Williams*, 338 F.3d 501, 515 (6th Cir. 2003).

20 CFR § 718.202(a) (2005) provides that a finding of the existence of pneumoconiosis may be based on (1) chest x-ray, (2) biopsy or autopsy, (3) application of the presumptions described in Sections 718.304 (irrebuttable presumption of total disability due to pneumoconiosis if there is a showing of complicated pneumoconiosis), 718.305 (not applicable to claims filed after January 1, 1982) or 718.306 (applicable only to deceased miners who died on or before March 1, 1978), or (4) a physician exercising sound medical judgment based on objective medical evidence and supported by a reasoned medical opinion. No autopsy has been performed. None of the presumptions apply, because the evidence does not establish the existence of complicated pneumoconiosis, the Claimant filed his claim after January 1, 1982, and he is still living. In order to determine whether the evidence establishes the existence of pneumoconiosis, therefore, I must consider the chest x-rays and medical opinions. As this claim is governed by the law of the Sixth Circuit, the Claimant may establish the existence of pneumoconiosis under any one of the alternate methods set forth at Section 718.202(a). *See Cornett v. Benham Coal Co.*, 227 F.3d 569, 575 (6th Cir. 2000); *Furgerson v. Jericol Mining, Inc.*, 22 B.L.R. 1-216 (2002) (*en banc*).

Pursuant to Section 718.304(a) the existence of complicated pneumoconiosis may be established when diagnosed by a chest x-ray which yields one or more large opacities (greater than 1 centimeter) and would be classified in Category A, B, or C. X-ray evidence is not the exclusive means of establishing complicated pneumoconiosis under Section 718.304. Its existence may also be established under Section 718.304 (b) by biopsy or autopsy or under

Section 718.304 (c), by an equivalent diagnostic result reached by other means. The Benefits Review Board has held that the Administrative Law Judge must first determine whether the relevant evidence in each category tends to establish the existence of complicated pneumoconiosis and then must weigh together the evidence at each subsection before determining whether invocation of the irrebuttable presumption under Section 718.304 has been established. *Melnick v. Consolidated Coal Co*., 16 B.L.R. 1-31, 1-33 (1991) (en banc). The United States Court of Appeals for the Fourth Circuit has held that "…even where some x-ray evidence indicates opacities that would satisfy the requirements of prong (A), if other x-ray evidence is available or if evidence is available that is relevant to an analysis under prong (B) [biopsy or autopsy] or prong (C) [other means] then all the evidence must be considered and evaluated to determine whether the evidence as a whole indicates a condition of such severity that it would produce opacities greater than one centimeter in diameter on an x-ray." *Eastern Associated Coal Corp. v. Director, OWCP (Scarbro)*, 220 F. 3d 250, 256 (4th Cir. 2000).

There is no chest x-ray interpretation of complicated pneumoconiosis on this record. Dr. Cai noted the presence of a seven millimeter nodule in the Miner's right upper lung based on a chest x-ray and CT-scan. Dr. Foust does not diagnose complicated pneumoconiosis in her biopsy report. Indeed, Dr. Jarboe reasonably concludes that Dr. Foust's observations of "extensive hyalinized nodularity" in the right upper lung was more compatible with a diagnosis of multiple nodules of simple coal workers' pneumoconiosis as opposed to a single lesion of sufficient size to constitute complicated pneumoconiosis under the regulations. In sum, there is no chest x-ray interpretation, CT-scan report, biopsy report, or medical opinion that diagnoses the presence of complicated pneumoconiosis and, consequently, I find that the Claimant has not demonstrated the presence of complicated pneumoconiosis such that the presumptions contained at § 725.304 are inapplicable.

Pneumoconiosis is a progressive and irreversible disease. *Labelle Processing Co. v. Swarrow*, 72 F.3d 308, 314-315 (3rd Cir. 1995); *Lane Hollow Coal Co. v. Director, OWCP*, 137 F.3d 799, 803 (4th Cir. 1998); *Woodward v. Director, OWCP*, 991 F.2d 314, 320 (6th Cir. 1993). As a general rule, therefore, more weight is given to the most recent evidence. See *Mullins Coal Co. of Virginia v. Director, OWCP*, 484 U.S. 135, 151-152 (1987); *Eastern Associated Coal Corp. v. Director, OWCP*, 220 F.3d 250, 258-259 (4th Cir. 2000); *Crace v. Kentland-Elkhorn Coal Corp*., 109 F.3d 1163, 1167 (6th Cir. 1997); *Rochester & Pittsburgh Coal Co. v. Krecota*, 868 F.2d 600, 602 (3rd Cir. 1989); *Stanford v. Director, OWCP*, 7 B.L.R. 1-541, 1-543 (1984); *Tokarcik v. Consolidated Coal Co*., 6 B.L.R. 1-666, 1-668 (1983); *Call v. Director, OWCP*, 2 B.L.R. 1-146, 1-148-1-149 (1979). This rule is not to be mechanically applied to require that later evidence be accepted over earlier evidence. *Woodward*, 991 F.2d at 319-320; *Adkins v. Director, OWCP*, 958 F.2d 49 (4th Cir. 1992); *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-600 (1984).

The March 17, 1993 study was interpreted as positive for the presence of pneumoconiosis by Dr. Bruton, a physician with no radiological qualifications. However, Dr. Sargent, a dually-qualified physician, concluded that the film's quality was unreadable due to overexposure, poor contrast, lack of sharp detail, and fogging. Because of Dr. Sargent's superior radiological qualifications, I find that this study is unreliable and cannot support a diagnosis of pneumoconiosis.

Dr. Bruton conducted a second study on April 27, 1993 and concluded that it demonstrated the presence of pneumoconiosis. Dr. Sargent reviewed the study and, although he found the study was of "marginal quality" and did not provide a specific ILO-U/C classification, he concluded that there were no parenchymal or pleural abnormalities consistent with pneumoconiosis. As previously noted, Dr. Sargent's interpretation is entitled to greater probative value given his superior radiological qualifications and the study does not support a finding of pneumoconiosis.

A study dated March 3, 1994 was interpreted by Dr. Gaziano, a B-reader, as demonstrating the presence of Category 1 pneumoconiosis. On the other hand, Dr. Sargent concluded that the study was negative for presence of the disease. Again, Dr. Sargent, as a dually-qualified physician, possesses radiological qualifications that are superior to the qualifications of Dr. Gaziano, a B-reader. This study does not support a finding of pneumoconiosis.

The July 30, 2002 study was read as positive for the presence of pneumoconiosis by Dr. Crater, a physician with no specialized radiological qualifications.[6] However, Dr. Wiot concluded that the study did not demonstrate the existence of coal workers' pneumoconiosis. Because he is a dually-qualified physician, Dr. Wiot's radiological qualifications are superior and this study does not support a finding of pneumoconiosis.

Dr. Jarboe, a B-reader, concluded that the February 2003 study conducted in conjunction with his examination of the Claimant was negative for the presence of pneumoconiosis. There are no contrary readings of this study such that it does not support a finding of the disease.

Finally, Dr. Jarvis, a physician without specialized radiological qualifications, interpreted the November 2003 study as negative for the presence of coal workers' pneumoconiosis. There are no contrary interpretations of this study and, as a result, it does not support a finding of the disease.

These constitute all of the x-ray interpretations in the record pertaining to the Claimant's claim. I have found that none of them supports a finding of pneumoconiosis. Consequently, the Claimant cannot be found to have pneumoconiosis on the basis of the x-ray evidence.

I must next consider the medical opinions. The Claimant can establish that he suffers from pneumoconiosis by well-reasoned, well-documented medical reports. A "documented" opinion is one that sets forth the clinical findings, observations, facts, and other data upon which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-22 (1987). An opinion may be adequately documented if it is based on items such as a physical examination, symptoms, and the patient's work and social histories. *Hoffman v. B&G Construction Co*., 8 B.L.R. 1-65, 1-66 (1985); *Hess v. Clinchfield Coal Co*., 7 B.L.R. 1-295, 1-296 (1984); *Justus v. Director, OWCP*, 6 B.L.R. 1-1127, 1-1129 (1984). A "reasoned" opinion is one in which the judge finds the underlying documentation and data adequate to support the

[6] Dr. Goldstein, a B-reader, reviewed the study solely for purposes of assessing whether it was of acceptable quality and he concluded that the study was Quality 1. DX 10.

physician's conclusions. *Fields*, above. Whether a medical report is sufficiently documented and reasoned is for the judge to decide as the finder-of-fact; an unreasoned or undocumented opinion may be given little or no weight. *Clark v. Karst-Robbins Coal Co*., 12 B.L.R. 1-149, 1-155 (1989) (en banc).

Of the physicians' opinions of record, only Dr. Jarvis concludes that the Miner does not suffer from coal workers' pneumoconiosis. All of the remaining physicians who address the issue, Drs. Gaziano, Bruton, Crater, and Jarboe, opine that coal workers' pneumoconiosis is present.[7]

As an initial matter, the qualifications of the physicians are relevant in assessing the respective probative values to which their opinions are entitled. *Burns v. Director, OWCP*, 7 B.L.R. 1-597, 1-599 (1984). Of the physicians whose qualifications are in the record, I note that Drs. Gaziano, Jarboe, and Jarvis are well-qualified as board-certified physicians in internal medicine and pulmonary diseases. Dr. Foust is also a well-qualified physician with board-certifications in anatomic and clinical pathology.

Turning to the medical evidence on this issue, I find that Dr. Jarvis' opinion that the Claimant does not suffer from coal workers' pneumoconiosis is entitled to little weight. He concluded that the Claimant did not suffer from the disease based on a negative chest x-ray interpretation and Dr. Foust's biopsy report, which Dr. Jarvis determined was "non-specific" and merely referred to the presence of "inflammatory tissue." Although Dr. Jarvis' negative x-ray interpretation is consistent with my findings of the x-ray evidence in this claim as a whole, his characterization of the biopsy findings is flawed. While Dr. Foust's biopsy report could benefit from more detailed findings, she did *specifically* note the presence of anthracosis and "extensive hyalinized nodularity in the lung" consistent with silicosis and coal workers' pneumoconiosis. Dr. Jarvis failed to acknowledge and address these findings, which clearly fall within the legal definition of clinical pneumoconiosis. From this, I cannot reconcile Dr. Jarvis' view that "[p]eople with zero exposure to coal dust could have an identical biopsy . . .." Indeed, Dr. Jarboe reasonably concluded that the Miner suffered from coal workers' pneumoconiosis based, in large part, on these biopsy findings.

Although supported by the conclusions of Drs. Gaziano, Crater, and Bruton, I find that Dr. Jarboe's opinion, that the Claimant suffers from coal workers' pneumoconiosis, is the most well-reasoned and well-documented. He conducted one of the more recent examinations of the Miner and reviewed certain medical records. With regard to his review of the medical records, I note that Dr. Jarboe accurately reported the observations of anthracosis, silicosis, and coal workers' pneumoconiosis contained in Dr. Foust's biopsy report and drew a reasonable conclusion that the Miner suffers from coal workers' pneumoconiosis as defined by the regulations. A medical opinion better supported by the objective medical evidence of record is entitled to more weight. *Minnich v. Pagnotti Enterprises, Inc*., 9 B.L.R. 1-89, 1-90 n.1 (1986).

[7] One of the Claimant's treating physicians, Dr. Cai, does not specifically address the presence or absence of coal workers' pneumoconiosis in his reports. His treatment records relate to the mass found in the Miner's right upper lung, which Dr. Cai indicated was "worrisome" for malignancy. Moreover, Dr. Cai does not offer an opinion as to the extent and etiology of any disability. As a result, his report and notes will not be discussed further.

In sum, I do not discredit any of the medical opinions of record. In resolving the conflict presented by the physicians of record, however, I find the opinion of Dr. Jarboe, as supported by the conclusions of Drs. Foust, Gaziano, Bruton, and Crater, to merit greater probative weight. Dr. Jarboe's credible and well reasoned medical opinion is convincing for purposes of establishing that the Claimant has coal workers' pneumoconiosis. This evidence out weighs the contrary conclusions provided by Dr. Jarvis. I conclude, therefore, that the weight of the medical opinions of record establishes that the Claimant has coal workers' pneumoconiosis as the Act requires for entitlement to benefits.

Causal Relationship Between Pneumoconiosis and Coal Mine Employment

The Act and the regulations provide for a rebuttable presumption that pneumoconiosis arose out of coal mine employment if a miner with pneumoconiosis was employed in the mines for ten or more years. 30 U.S.C. § 921(c)(1); 20 CFR § 718.203(b) (2005). The Claimant was employed as a miner for at least 16.5 years and, therefore, is entitled to the presumption. This presumption is supported by the most well-reasoned, well-documented medical opinion of Dr. Jarboe. The biopsy findings of Dr. Foust and medical opinions of Drs. Gaziano, Bruton, and Crater also support invocation of this presumption. As previously discussed, I have found Dr. Jarvis' opinion unpersuasive on the issue of whether the Claimant suffers from coal workers' pneumoconiosis and it is insufficient to rebut the presumption. Therefore, I conclude that the Claimant's pneumoconiosis was caused by his coal mine employment.

Total Pulmonary or Respiratory Disability

A miner is considered totally disabled if he has complicated pneumoconiosis, 30 U.S.C. § 921(c)(3), 20 CFR § 718.304 (2005), or if he has a pulmonary or respiratory impairment to which pneumoconiosis is a substantially contributing cause, and which prevents him from doing his usual coal mine employment and comparable gainful employment, 30 U.S.C. § 902(f), 20 CFR § 718.204(b) and (c) (2005). The regulations provide five methods to show total disability other than by the presence of complicated pneumoconiosis: (1) pulmonary function studies; (2) blood gas studies; (3) evidence of cor pulmonale; (4) reasoned medical opinion; and (5) lay testimony. 20 CFR § 718.204(b) and (d) (2005). Lay testimony may only be used in establishing total disability in cases involving deceased miners, and in a living miner's claim, a finding of total disability due to pneumoconiosis cannot be made solely on the miner's statements or testimony. 20 CFR § 718.204(d) (2005); *Tedesco v. Director, OWCP*, 18 B.L.R. 1-103, 1-106 (1994). There is no probative evidence in the record that the Claimant suffers from complicated pneumoconiosis or cor pulmonale. Thus, I will consider pulmonary function studies, blood gas studies and medical opinions. In the absence of contrary probative evidence, evidence from any of these categories may establish disability. If there is contrary evidence, however, I must weigh all the evidence in reaching a determination whether disability has been established. 20 CFR § 718.204(b)(2) (2000); *Fields v. Island Creek Coal Co.*, 10 B.L.R. 1-19, 1-21 (1987); *Shedlock v. Bethlehem Mines Corp.*, 9 B.L.R. 1-195, 1-198 (1986).

I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1-154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel*

Corp., 9 B.L.R. 1-131, 1-133–134 (1986). Little or no weight may be accorded to a ventilatory study if the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co*., 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945, 1-946–947 (1984); *Justice v. Jewell Ridge Coal Co*., 3 B.L.R. 1-547, 1-551 (1981).

With regard to the ventilatory study evidence, only Dr. Crater's July 2002 study yielded qualifying values under the regulations. Although Dr. Michos validated the FEV1 and FVC maneuvers for this study, Drs. Jarvis and Jarboe concluded that the study was invalid due to poor effort. Indeed, Dr. Crater, the physician who conducted the study, questioned the Miner's effort on the test. I find that this test does not provide a reliable assessment of the Claimant's pulmonary function, particularly in light of the non-qualifying studies conducted before and after the July 2002 test. Notably, the more recent February and November 2003 studies conducted by Drs. Jarboe and Jarvis, respectively, produced significantly improved values that were non-qualifying. On balance, I conclude that the Claimant has not demonstrated total disability through the ventilatory testing of record.

Turning to the blood gas testing, none of the studies produced qualifying values. As a result, the Claimant has not demonstrated total disability through this evidence.

Of the physicians who addressed the extent of the Claimant's pulmonary or respiratory disability, Drs. Gaziano, Crater, and Jarboe conclude that the Miner suffers from a totally disabling respiratory impairment.[8] Drs. Bruton and Jarvis, on the other hand, opine that the Claimant suffers from no respiratory or pulmonary impairment.

After consideration of the data and reasoning contained in the reports, I find Dr. Jarboe's report is the most persuasive. First, as already noted, his opinion is based on examination and testing of the Miner, including a diffusion capacity test, as well as a review of certain medical records. This data afforded Dr. Jarboe a more complete picture of the Miner's condition. A medical opinion which is supported by more extensive documentation is entitled to greater weight than an opinion based on more limited medical data. *Sabett v. Director, OWCP*, 7 B.L.R. 1-299, 1-301 n. 1 (1984).

Second, Dr. Jarboe conducted one of the most recent examinations of the Miner. Since pneumoconiosis is a progressive and irreversible disease, I find that more recent data utilized by Dr. Jarboe enhances the probative value of his opinion.

Third, although the valid ventilatory and blood gas testing of record produced non-qualifying values, Dr. Jarboe's finding of a totally disabling respiratory impairment is well-reasoned and well-documented. In particular, Dr. Jarboe was one of two physicians to measure the Miner's diffusion capacity. He found a moderate reduction in the diffusion capacity during

[8] Dr. Crater concluded that the Miner suffered from a mild to moderate respiratory impairment due, in part, to coal workers' pneumoconiosis. Based on the Claimant's description of his work requirements, *i.e.* crawling 100 yards a day and using a hydraulic drill bolt machine to place three and six foot steel plates in the roof of the mine, I find that the Claimant engaged in sustained heavy manual labor. Comparing the exertional requirements of his last job with the physical limitations noted by Dr. Crater, I find that Dr. Crater has diagnosed a totally disabling respiratory impairment.

his 2003 examination, which is the same finding made by Dr. Gaziano after he conducted such a study nine years earlier. Dr. Jarboe reasonably explained that a moderately reduced diffusing capacity on exercise means that the Miner's oxygen tension dropped significantly during exercise, which would render the Miner unable to perform the sustained hard manual labor required of his last job as a roof bolter. Thus, Dr. Jarboe's conclusion is supported by the diffusion capacity data underlying his report. *See Minnich, supra*.

Of the two physicians who conclude that the Claimant does not suffer from a totally disabling respiratory impairment, Dr. Bruton's opinion is unpersuasive for three reasons. First, his report is based on limited medical data. Unlike Dr. Jarboe, Dr. Bruton did not review other medical records in addition to his examination of the Miner. Moreover, Dr. Bruton did not have the benefit of considering data from the Miner's diffusion capacity test conducted earlier by Dr. Gaziano, nor did Dr. Bruton conduct such a study of his own.

Second, Dr. Bruton's opinion is based on data obtained in 1995. Because pneumoconiosis is a progressive and irreversible disease process, recent testing and examinations of the Miner afford a more accurate assessment of his current condition. Thus, Dr. Bruton's report loses probative force on this ground as well.

Third, Dr. Bruton noted in his report that the Claimant's "[r]ecent treadmill test showed (the Claimant's) exercise tolerance to be (one-third) of predicted (but the) heart was reportedly OK." Dr. Bruton fails to discuss the relevance of this observation in light of the sustained heavy manual labor the Claimant performed as a roof bolter. Indeed, it is unclear whether Dr. Bruton was knowledgeable of the specific duties required of the Claimant in performing his last job as a miner. As a result, Dr. Bruton's report is accorded less weight as undocumented.

Dr. Jarvis' finding of no totally disabling respiratory or pulmonary impairment is also unpersuasive. Although he conducted one of the recent examinations of the Miner and reviewed certain medical records, Dr. Jarvis did not conduct a diffusing capacity test. As a result, he had a less complete set of medical data than did Dr. Jarboe for use in assessing the extent of the Claimant's total disability.

When asked about the significance of Dr. Jarboe's diffusing capacity test results during a deposition, Dr. Jarvis asserted that "diffusion capacities are very variable and often unreliable" such that he would repeat the test "once or twice" before basing an opinion on the data. It is evident that Dr. Jarboe did not consider the diffusing capacity test underlying his report as "unreliable." Indeed, as previously noted, the only other diffusion capacity study conducted in this claim was by Dr. Gaziano in 1994 and he, too, found a "moderate" reduction in the Miner's capacity at the time. Dr. Jarvis never addresses the consistent findings yielded by diffusion capacity studies conducted by Drs. Gaziano and Jarboe over time, which seem to demonstrate the consistent, reliable results Dr. Jarvis seeks.

In addition, Dr. Jarvis reported that the Miner complained of shortness of breath "sometimes" and that he remained "quite active with no impairment of his normal daily activities." This is inconsistent with the complaints reported by other physicians of record as well as my observations of the Claimant as he credibly testified on this issue at the hearing. Dr.

Gaziano reported complaints of shortness of breath "with very little activity." Dr. Bruton noted complaints of shortness of breath with "moderate activity such as brisk walking or climbing hills." Nearly seven years later, Dr. Crater stated that the Miner complained of wheezing and dyspnea usually in conjunction with strenuous activity such as mowing. Dr. Jarboe stated that the Miner complained of shortness of breath after walking on level ground for one block and that he suffered from dyspnea while using a self-propelled mower. This is consistent with the Claimant's testimony at the hearing where he stated that it takes him two days to mow a one-half acre piece of land with his self-propelled mower because he has to repeatedly stop and rest. It is evident that these complaints reflect physical limitations that would render the Claimant unable to perform the sustained heavy manual labor required of a roof bolter.

Although subjective complaints of shortness of breath, standing alone, are insufficient to determine whether the Miner suffers from a totally disabling respiratory impairment, these complaints are consistent with the moderate reduction of oxygen tension on exercise noted by Drs. Jarboe and Gaziano and further support my finding, based on the persuasive medical opinion evidence of record, that the Claimant suffers from a totally disabling respiratory impairment.

Causation of Total Disability

In order to be entitled to benefits, the Claimant must establish that pneumoconiosis is a "substantially contributing cause" to his disability. A "substantially contributing cause" is one which has a material adverse effect on the miner's respiratory or pulmonary condition, or one which materially worsens another respiratory or pulmonary impairment unrelated to coal mine employment. 20 CFR § 718.204(c) (2005); *Grundy Mining Co. v. Director, OWCP [Flynn]*, 353 F. 3d 467, 483 (6th Cir. 2003) (case decided under the "old" rules); *Tennessee Consol. Coal Co. v. Kirk*, 264 F.3d 602, 610 (6th Cir. 2001) (case decided under the "new" rules).

The Benefits Review Board has held that Section 718.204 places the burden on the claimant to establish total disability due to pneumoconiosis by a preponderance of the evidence. *Baumgardner v. Director, OWCP*, 11 B.L.R. 1-135 (1986). Nothing in the commentary to the new rules suggests that this burden has changed; indeed, some language in the commentary indicates it has not changed. See 65 Fed. Reg. at 79923 (2000) ("Thus, a miner has established that his pneumoconiosis is a substantially contributing cause of his disability if it either has a material adverse effect on his respiratory or pulmonary condition or materially worsens a totally disabling respiratory or pulmonary impairment …").

Initially, I note that there are inconsistencies in the record regarding the extent of the Miner's smoking history and this has direct bearing on the probative value of the physicians' opinions regarding the cause of the Miner's disabling respiratory impairment. Dr. Bruton noted that the Claimant never smoked. Dr. Gaziano stated only that the Miner had "smoked cigars on social occasions for three years." Dr. Cai, one of the Claimant's treating physicians, stated in his January 2002 report, that the Claimant had smoked one pack of cigarettes per day for 12 years. Dr. Crater reported that the Miner had smoked one-half a pack of cigarettes per day since the age of 25 years. Dr. Jarboe noted that the Claimant smoked one-half a pack of cigarettes per day since his "late teens or early 20s." However, during his deposition, Dr. Jarboe testified that when

the patient history form was completed at his office, it was noted that the Claimant smoked one pack of cigarettes per day. Dr. Jarvis noted that the Miner smoked one pack of cigarettes per day, but did not state when the Miner began smoking. In his October 26, 2002 answers to the Employer's interrogatories, the Claimant was unsure of the date he started smoking and stated that he smoked one pack of cigarettes per day but, at some undetermined point in time, he reduced his smoking habit to one-half a pack of cigarettes per day.

At the hearing, the Claimant testified that he began smoking at the age of 21 or 22 years. This is roughly consistent with the reported start dates noted by Drs. Crater and Jarboe. As a result, I find that the Claimant's testimony is credible on this point and conclude that he started smoking cigarettes around the age of 21 or 22 years.

With regard to the quantity of cigarettes consumed per day, the Miner testified that he smokes one-half a pack of cigarettes per day and will occasionally smoke a cigar. I find that a current, reduced smoking habit of one-half a pack of cigarettes per day is consistent with the carboxyhemoglobin level at the time of Dr. Jarboe's February 2003 examination, which was at the "upper limit of normal." However, I also find that, based on the Claimant's written responses to the Employer's interrogatories in October 2002, he had smoked one pack of cigarettes per day at one time. Because the Claimant could not remember the approximate date on which he reduced his cigarette consumption, I find that he smoked one pack of cigarettes per day until the date of his October 2002 answers to the Employer's interrogatories.

In sum, I find that the Claimant started smoking one pack of cigarettes per day from approximately 1958 and continuing until October 2002 for a total of 44 years. He has since smoked one-half a pack of cigarettes per day. This smoking history is most closely reflected in Dr. Jarboe's medical report.

With regard to the medical evidence addressing disability causation, I note that there is no probative medical opinion concluding that the Claimant's totally disabling respiratory impairment is due, at least in part, to coal workers' pneumoconiosis. In particular, Dr. Gaziano's report is silent on the issue of disability causation. Dr. Bruton never reached the issue because he concluded that the Miner did not suffer from a totally disabling respiratory impairment. Dr. Cai's report is silent on all medical entitlement issues. Dr. Jarvis concluded that the Claimant did not suffer from coal workers' pneumoconiosis or a totally disabling respiratory impairment.

Although Dr. Crater stated that the Miner's respiratory impairment, to the extent he could assess the impairment, was due in part to coal dust exposure, his opinion is accorded little weight as compared to the more current and comprehensive report of Dr. Jarboe. Importantly, Dr. Jarboe had the benefit of Dr. Foust's biopsy findings with regard to the disease processes present in the miner's lungs. Although simple coal workers' pneumoconiosis was seen, Dr. Jarboe stated that the significantly reduced diffusing capacity was the result of smoking induced diseases of desquamative interstitial pneumonia (DIP), interstitial fibrosis, and emphysema. Dr. Jarboe persuasively explained that coal workers' pneumoconiosis causes, at most, mildly reduced diffusing capacity and it would be "very unusual" for such a disease to produce the marked reduction present in this case. Dr. Jarboe correctly notes that Dr. Foust never observed that the interstitial fibrosis and emphysema observed in the Miner's lungs were affiliated with coal dust

deposition and he testified that DIP is "a very specific type of inflammatory lesion in the lung that is seen only in cigarette smokers." As previously noted, Dr. Jarboe's opinion contains the most accurate description of the Claimant's smoking history. Consequently, I find that the preponderance of the evidence does not establish that the Claimant's respiratory impairment is due to coal dust exposure.

FINDINGS AND CONCLUSIONS REGARDING ENTITLEMENT TO BENEFITS

Because the Claimant has failed to meet his burden to establish that he is totally disabled due to coal workers' pneumoconiosis, he is not entitled to benefits under the Act.

ATTORNEY FEES

The award of an attorney's fee under the Act is permitted only in cases in which the claimant is found to be entitled to benefits. Section 28 of the Longshore and Harbor Workers' Compensation Act, 33 U.S.C. § 928, as incorporated into the Black Lung Benefits Act, 30 U.S.C. § 932. Since benefits are not awarded in this case, the Act prohibits the charging of any fee to the Claimant for services rendered to him in pursuit of this claim.

ORDER

The claim for benefits filed by Junior Lowe on January 28, 1993 is hereby DENIED.

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ALICE M. CRAFT
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 CFR § 725.481 (2005), any party dissatisfied with this decision and order may appeal it to the Benefits Review Board within 30 days from the date of this decision and order, by filing a notice of appeal with the Benefits Review Board at P.O. Box 37601, Washington, DC 20013-7601. A copy of a notice of appeal must also be served on Donald S. Shire, Esq. Associate Solicitor for Black Lung Benefits. His address is Frances Perkins Building, Room N-2117, 200 Constitution Ave., NW, Washington, D.C. 20210.